570-1
The following is an overview of the Medi-Cal waiver process.

The applicant must be Medi-Cal eligible in the non-institutional setting before being served by a waiver. Depending on the circumstances, this determination may be initiated while the applicant is still institutionalized or in a living arrangement different from the setting covered by the waiver. Agencies responsible for waiver service authorization will refer waiver applicants to the county welfare department (CWD) for these eligibility determinations.

A. Medi-Cal Eligibility Waiver Determination -- Overview

There are several factors counties must consider such as the following:

1. Whether eligibility is to be based on regular Medi-Cal rules or special Medi-Cal rules depending on the type of waiver that the applicant will be in.

2. Whether the determination is based on anticipated circumstances or on actual circumstances.

3. Whether the individual is a New Applicant or a Beneficiary with a Change in Circumstances.

> New Applicant:

If the waiver applicant is not currently receiving Medi-Cal, he/she must complete an Application for Public Assistance and a Statement of Facts.

The individual who is not currently receiving Medi-Cal will need an initial Medi-Cal eligibility determination based on his/her anticipated living situation. If the applicant has a parent or spouse in the home, the major concern is usually whether he/she will be eligible or have a high SOC due to parental or spousal income or excess property.

> Beneficiary with a Change in Circumstances:

In some cases, the waiver applicant will be institutionalized and Medi-Cal eligible as an institutionalized individual prior to a referring agency contacting the CWD; however, depending on the waiver and circumstances, many persons may already be deinstitutionalized prior to requesting an eligibility determination.

If the waiver applicant is currently receiving Medi-Cal-Only, the individual's move from an institutional setting to a non-institutional setting or from one community setting to another community setting generally will be treated by the county as a change in circumstances rather than a new application. The applicant does not complete a new Application for Public Assistance, but the county may require a new Statement of Facts if appropriate.

If the person is currently institutionalized and is already receiving Medi-Cal, a new eligibility determination based on a non-institutional living arrangement is required prior to the person begin discharged either to the home of his/her spouse or parents or to a community setting to ensure continuing Medi-Cal eligibility so he/she can receive waiver services. NOTE: Once the county receives a referral, the county will determine Medi-Cal eligibility based on the criteria for the appropriate waiver including the living arrangement covered by the waiver.

(Medi-Cal Eligibility Procedures Manual (MEPM) §19D-2, 3, as revised December 12, 2001)

570-2
There are six types of waivers. The first two have special Medi-Cal eligibility determination requirements. The last four follow regular eligibility rules.

A. Department of Developmental Services Home and Community-Based (DDS) Waiver

B. Model-Nursing Facility (Model-NF)

C. In-Home Medical Care Services (IHMC) Waiver

D. Nursing Facility (NF) Services Waiver

E. Acquired Immune Deficiency Syndrome (AIDS) Waiver

F. Multipurpose Senior Service Program (MSSP) Waiver

(Medi-Cal Eligibility Procedures Manual (MEPM) §19D-3)

570-3
All waiver applicants should receive a Notice of Action (NOTICE OF ACTION) approving or denying Medi-Cal eligibility. The county will send an NOTICE OF ACTION to the applicant and copy to the appropriate State referring agency or Regional

Center. Model Nursing and DDS waiver applicants have special NOAs. The Office of AIDS sends out a special NOTICE OF ACTION.

(Medi-Cal Eligibility Procedures Manual §19D-10)

570-4
The effective date of Medi-Cal coverage for applicants of a waiver where the waiver has special eligibility rules should be the date the following two requirements are met:

1. The referring agency determines that it is medically appropriate for the waiver applicant to be in that waiver, and

2. The county determines that the waiver applicant meets the Medi-Cal eligibility requirements under that waiver.

Counties should contact In-Home Operations (IHO) or the Regional Center to determine the effective date unless it is indicated on the referral form. NOTE: Retroactive eligibility rules as stated in §50710 (now §50197) of the California Code of Regulations (CCR) remain in effect.

(Medi-Cal Eligibility Procedures Manual (MEPM) §19D-10)

570-5
There may be waiver persons requesting In-Home Supportive Services IHSS). The IHSS residual component does not waive parental income and resources of parents or use spousal impoverishment rules; therefore, it is unlikely that the beneficiary will be eligible. Counties may refer these persons to the PCSP component of IHSS; however, a parent or spouse may not be the provider of services.

(MEPM §19D-11)

570-6
Persons in the Model Nursing and DDS waivers are in their own MFBU. Spousal impoverishment rules apply. Since the waiver person is in his/her own MFBU, the maintenance need or income limit for the waiver person is based on a family size of one. If there are multiple persons in the same household applying for these waivers, each person is in his/her own MFBU. If other family members are applying for or are receiving regular Medi-Cal, the Model or DDS waiver person should be treated similarly to public assistance (PA) persons, e.g., they are not in the MFBU with other family members; however, they may be used to link other family members. Persons applying for the other four waivers are considered part of the household if they are determined to be living in the home; therefore, regular Medi-Cal MFBU rules apply. NOTE: If it is more beneficial for the person to be in the MFBU with the other family members, the waiver applicant may choose not to be in the waiver and to be determined under regular Medi-Cal rules. The county should notify the referring agency of this decision.

(MEPM §19D-11)

571-1
The regional centers of the Department of Developmental Services (DDS) are responsible for the Home and Community-Based Services (HCBS) Waiver

1. Description (from the Medi-Cal Eligibility Procedures Manual (MEPM):

   The DDS HCBS waiver is limited to developmentally disabled children and adults who live at home and meet the admission criteria for an intermediate care facility fo rthe developmentally disabled as defined in the California Health and Safety Code. Waiver eligibility will be determined by the regional centers, but counties are responsible for the Medi-Cal determination. Services provided include homemaker, home health, residential habitation, day habitation, skilled nursing, transportation, specialized medical equipment and supplies, personal care, respite, environmental modifications, chore service, personal emergency response systems, physical therapy, occupational therapy, physiology services, vehicle adaptations, communication aides, and crisis intervention.

2. Referring Agency: DDS -- Regional Centers

   DDS contracts with local regional centers which are responsible for seeking Medi-Cal for their clients. The regional center will determine the medical appropriateness of waiver coverage before referral to the County Welfare Department (CWD) by reviewing the applicant's medical, social, and developmental care needs. If appropriate, the regional center will refer him/her to the county for an eligibility determination or redetermination via the DDS Waiver Referral form (DHS 7096). If no responsible relative is available to act on the applicant's behalf or he/she does not wish to apply for the applicant, the regional center may do so, although they may not necessarily be the child's conservator. Counties may share ongoing eligibility information with the regional centers regardless of who acts on the client's behalf.

(MEPM §19D-4)

571-2
The individual applying for the DDS Home and Community-Based Services waiver must meet all standard Medi-Cal eligibility rules such as California residency and cooperation.

> If the individual is eligible for Medi-Cal with no share of cost (SOC) without using the special waiver rules, he/she is not eligible for the waiver. The county should contact the regional center and inform their contact that the waiver is not appropriate. However, if after a preliminary screening, it appears that the applicant will be property ineligible or has an SOC using parental or spousal income and property, the special rules below apply:

> The applicant is treated as if he/she were institutionalized for purposes of the treatment of income and resources.

> If the applicant is a child, parental income and resources are not considered even though the child lives in the home.

> If the applicant is an adult, spousal impoverishment rules apply.

> A second vehicle is exempt if the vehicle has been modified to accommodate the physical handicap(s) or medical needs of the individual. Verification shall be by the physician's written statement of necessity.

> The individual is in his/her own MFBU. If other family members wish to be aided, the individual is treated similar to those on public assistance (PA), e.g., the individual may be used to link other family members although the individual is not in the family's MFBU.

> The waiver is limited to those who are eligible with or without an SOC for full benefits.

> The county should use the most beneficial full scope Medi-Cal program to determine eligibility that is applicable to the applicant. Eligibility is based on the waiver individual's own income and resources, including amounts remaining after spousal impoverishment rules are applied.

For example: A child under age 19 who has an SOC in the MN or MI program or excess property may be eligible under the appropriate Percent program which disregards property using a family size of one.

> A disability determination is not required unless (1) eligibility is based on a Medi-Cal program requiring that the individual be disabled, (2) the individual has no other basis for linkage or, (3) there would be an advantage if the applicant were disabled, e.g., income deductions available only to the disabled. This determination of disability may be advantageous in the future when the child becomes an adult.

> Aid codes for the DDS Waiver are:

6V No SOC 6W SOC

In some counties, persons in 6V may choose to be in a managed care plan. It is not mandatory.

(MEPM §19D-4, 5)

572-1

The Model-Nursing Facility (NF) waiver is limited to persons who in the absence of the waiver program would otherwise require the nursing facility level of care or sub-acute services for at least 90 consecutive days but who wish to live at home or in the community. Individuals under the age of 21 must be able to access a waiver service which is not covered under the EPSDT program. Inpatient status prior to the enrollment of waiver services is not required. Services provided include but are not limited to: case management, skilled nursing, home health aides, language services, speech, hearing, family training and therapy, and physical therapy and adaptations to the home.

(Medi-Cal Eligibility Procedures Manual (MEPM) §19D-5, 6)

572-2
In the Model-NF waiver, the purpose of the DHS In-Home Operations (IHO) is to ensure that necessary, appropriate, and quality medical and nursing services are authorized and provided in the home setting. IHO staff facilitate the proposal documentation and development between each waiver participant and provider. This process allows for review of all issues related to the recipient level of care, evaluation of Durable Medical Equipment, medication, nursing hours, cost-effectiveness and verification by IHO staff that the home environment is appropriate to meet the health and safety needs of the recipient. Final approvals of individual waiver requests are subject to review by a Medi-Cal physician and other staff.

(MEPM §19D-6)

572-3
The Model-NF waiver has the same Medi-Cal eligibility rules as the DDS waiver. The requirements are:

The individual must meet all standard Medi-Cal eligibility rules such as California residency and cooperation when determining eligibility for the waiver.

> If the individual is eligible for Medi-Cal with no SOC without using the special waiver rules, he/she is not eligible for the waiver. The county should contact In-Home Operations (IHO) and inform the contact that the waiver is not appropriate. However, if after a preliminary screening, it appears that the applicant will be property ineligible or has an SOC using parental or spousal income and property, the special rules below apply:

> The applicant is treated as if he/she were institutionalized for purposes of the treatment of income and resources.

> If the applicant is a child, parental income and resources are not considered even though the child lives in the home.

> If the applicant is an adult, spousal impoverishment rules apply.

> A second vehicle is exempt if the vehicle has been modified to accommodate the physical handicap(s) or medical needs of the individual. Verification shall be by the physician's written statement of necessity.

> The individual is in his/her own MFBU. If other family members wish to be aided, the individual is treated similarly to those on public assistance (PA) e.g., the individual may be used to link other family members although the individual is not in the family's MFBU.

> The waiver is limited to those who are eligible with or without an SOC for full (not restricted) benefits.

> The county should use the most beneficial full scope Medi-Cal program to determine eligibility that is applicable to the applicant. Eligibility is based on the waiver individual's own income and resources, including amounts remaining after spousal impoverishment rules are applied.

For example: A child under age 19 who has an SOC in the MN or MI program or excess property may be eligible under the appropriate Percent program which disregards property using a family size of one.

> A disability determination is not required unless (1) eligibility is based on a Medi-Cal program requiring that the individual be disabled, (2) the individual has no other basis for linkage or, (3) there would be an advantage if the applicant were disabled, e.g., income deductions available only to the disabled. This determination of disability may be advantageous in the future when the child becomes an adult.

> Aid Codes for the In-Home Medical Care (Model) Waiver are:

6X Model Waiver No SOC 6Y Model Waiver SOC

In some counties, persons in 6X may choose to be in a managed care plan. It is not mandatory.

(MEPM §19D- 6, 7, 8)

573-1
The Nursing Facility Level of Care (NF) waiver (formerly referred to as the Skilled Nursing Facility Waiver) is limited to individuals who in the absence of the waiver program would require care in a nursing facility or a sub-acute facility for at least 90 consecutive days care. Services provided include, but are not limited to: case management, skilled nursing, home health aides, language services, speech, hearing, family training and therapy, physical therapy and adaptations to the home. Individuals under the age of 21 may access services under the NF waiver that are not covered under the EPSDT program.

Referring Agency: DHS In-Home Operations (IHO).

Generally, if the applicant is not referred, the county probably will not be aware that the applicant is seeking a waiver and will process the determination as they normal do.

Eligibility Requirements

No special Medi-Cal eligibility rules apply. If the applicant is living in the home, he/she is not a separate MFBU from his/her parent/spouse.

(Medi-Cal Eligibility Procedures Manual (MEPM) §19D-8,9)

574-1
The Acquired Immune Deficiency Syndrome (AIDS) waiver is limited to persons with a diagnosis of Human Immunodeficiency or AIDS with symptoms related to Human Immunodeficiency Virus (HIV) disease who would otherwise require care in skilled nursing facilities or acute hospitals. Services provided include case management, skilled nursing, attendant care, psycho-social counseling, non-emergency medical transportation, homemaker services, specialized medical equipment and supplies, minor physical adaptations to the home, a limited supplement for infants and children in foster care, nutritional counseling, and nutritional supplements/home delivered meals.

No special Medi-Cal eligibility rules apply.

(Medi-Cal Eligibility Procedures Manual §19D-9)

575-1
The In-Home Medical Care (IHMC) waiver is limited to individuals who in the absence of the waiver program require care in an acute hospital for at least 90 days. Services provided include but are not limited to: case management, skilled nursing, home health aides, utility coverage, case management, and minor physical adaptations to the home.

Referring Agency: DHS In-Home Operations (IHO).

Generally, if the applicant is not referred, the county probably will not be aware that the applicant is seeking a waiver and will process the determination as they normally do.

Eligibility Requirements

No special Medi-Cal eligibility rules apply. If the applicant is living in the home, he/she is not in a separate MFBU from his/her parent/spouse.

(Medi-Cal Eligibility Procedures (MEPM) §19D-8)

576-1

The Multipurpose Senior Services Program (MSSP) is a program designed to serve frail individuals 65 years of age or older, who are certifiable for placement in a nursing facility. The MSSP is to be structured and carried out in a manner consistent with 42 United States Code §1396n(c). (W&IC §9560(a), effective January 1, 1997)

576-1A
The Department of Aging Multipurpose Senior Services Program Waiver (MSSP) provides non-traditional Medi-Cal community-based services to persons 65 years and older who meet the Medi-Cal criteria for inpatient care in a nursing facility. Program eligibility requirements are:

> Age 65 or older.

> Receive full-scope Medi-Cal under an acceptable aid code.

> Certifiable for placement in a nursing facility.

> Live within a site's service area.

> Able to be served within the program's cost limitations.

> Appropriate for care management services.

The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. The services must be provided at a cost lower than that for nursing facility care.

(All-County Welfare Directors Letter No. 03-22, April 25, 2003)

576-2
MSSP services consist of, but are not limited to, senior center programs; transportation; income maintenance counseling; volunteer programs; and the following services: case management; recreation; educational; information and referral; housing; outreach; legal; home repair; escort; telephone reassurance; friendly visiting; health and psychological assessment; nutrition; home health; preventive health; mental health; homemaker chore; meals; adult day care, including health care; and nonmedical respite care. (W&IC §9561, effective January 1, 1997)

576-3
State law gives the CDSS the authority, to the extent permitted by federal law, to waive regulations and general policies and make resources available which are necessary for the administration of Welfare & Institutions Code (W&IC) §9560 and following. (W&IC §9562(b))

Pursuant to this authority, the CDSS has authorized the MSSP to supplement their clients' IHSS awards as follows:

(a) For cases authorized to receive the statutory maxima, there will be no reduction in the authorization of services when the MSSP grants an additional level of services above the IHSS maxima.

(b) For cases assessed at a level less than the maxima, additional hours authorized by the MSSP will not be considered an alternative resource, and IHSS will be authorized at the previously determined need level.

(All-County Letter No. 00-34, May 19, 2000)

576-4
The Multipurpose Senior Service Program (MSSP) waiver program is limited to the frail elderly who authorized representative over sixty-five years of age and receive Medi-Cal under an appropriate aid code. MSSP clients reside in their own homes within a particular service area. Potential clients are screened for eligibility as to Level of Care (LOC) Determination and must be certifiable for placement in a nursing facility. Clients have to be appropriate for case management services and be able to be served within MSSP's cost limitations.

MSSP provides interdisciplinary case management services including the coordination and use of existing community resources. Case managers initiate and oversee the process of assessments, care plan development, service arrangement, ongoing monitoring and reassessments. Clients may be linked to services including but not limited to: housing assistance, protective services, personal care, respite care, transportation, meal services, and special communications. Case managers can authorize the purchase of services with waiver funds when there is no existing community resource to meet client needs. Case managers are responsible for the provision and ongoing review of services in the client's plan of care.

(MEPM §19D-9)

576-5
MSSP clients must have one of the following qualifying Medi-Cal aid codes: 10, 14, 16, 18, 1H, 20, 24, 26, 28, 60, 64, 66, 68, and 6H. Three other aid codes may be eligible for MSSP: 17, 27, and 67; these are only eligible with the supplemental identifying aid codes of 1F, 2F or 6F. Applicants who appear eligible for Medi-Cal but are not receiving benefits should be referred to the county welfare department for Medi-Cal eligibility determination. No special Medi-Cal eligibility rules apply.

(MEPM §19D-10)

576-6
The California Department of Aging (CDA) has an inter-agency agreement with the Department of Health Services (DHS), which is the single State Medicaid agency.

Within CDA, the MSSP Section of the Medi-Cal Services Branch is the unit responsible for reviewing and monitoring MSSP sites for contract compliance.

(MEPM §19D-10)

576-7
Individuals who are Medi-Cal eligible using regular income and property rules (including spousal impoverishment if they are institutionalized and have community spouses) and who need MSSP services are evaluated by the MSSP program to determine whether they meet the MSSP criteria. These individuals may currently be in a nursing facility and wish to return to the home of their spouse or are already living at home with their spouse.

When the county determines that the individual will be property ineligible or has an SOC using regular rules, the waiver allows institutional deeming rules to apply. The Medi-Cal MSSP eligibility determination is as follows:

> The applicant/beneficiary is treated as if he or she was institutionalized for purposes of the treatment of income and resources.

> Spousal impoverishment rules apply.

> The MSSP individual is in his/her own Medi-Cal Family Budget Unit (MFBU). If other family members wish to be aided, the individual is treated similar to those on public assistance, e.g., the individual may be used to link other family members although the individual is not in the family's MFBU.

> The MSSP individual must be eligible for full benefits with or without an SOC. NOTE: A person residing in a nursing home under the limited state-only Aid Code of 53, a person in another limited-scope aid code, or a person who does not have satisfactory immigration status is not eligible.

> The county should use the most beneficial full-scope Medi-Cal program to determine eligibility that is applicable to the applicant. Eligibility is based on the individual's own income and resources, including amounts remaining after spousal impoverishment rules are applied.

(All-County Welfare Directors Letter No. 03-22, April 25, 2003)